DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535040	A. BUILDING _____ B. WING _____	C 10/06/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1108 BIRCH STREET DOUGLAS, WY 82633

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F 000	INITIAL COMMENTS A complaint survey was conducted in conjunction with the recertification survey by Healthcare Licensing and Surveys on 10/3/16 through 10/6/16. The survey was prompted by complaint intakes WY00002212 and WY00002266. It was determined, based upon the findings of the survey team, that no deficiencies were identified pertaining to the complaint investigation. The following common abbreviations are used throughout this document: CNA Certified Nurse Aide DON Director of Nursing LPN Licensed Practical Nurse MDS Minimum Data Set Less commonly used abbreviations will be annotated in each deficiency.	F 000	F154 The facility will ensure that those residents are notified in advance of medical appointment. a) All residents will be notified in advance of medical appointments unless residents have a history of becoming anxious and/or agitated and/or worried of upcoming medical appointments. Those residents who do not do well knowing in advance of medical appointments will be care planned as such. b) A form will be developed in our EMAR system that will document when and how residents were notified of upcoming medical appointments.	
F 154 SS=D	483.10(b)(3), 483.10(d)(2) INFORMED OF HEALTH STATUS, CARE, & TREATMENTS The resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. The resident has the right to be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to ensure residents were notified in	F 154	c) The van driver or designee will be responsible for notifying the residents of upcoming medical appointments and documenting in EMAR system of notification. d) Van driver and medical records will be educated on the need to inform residents of medical appointments in advance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 10/27/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Changes made per phone call with Kelli Poffe, NHA on 10/31/16 @ 8:47am.

RECEIVED
OCT 27 2016
Healthcare Licensing and Surveys

POC accepted. DOC - 11/18/16

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F 154	Continued From page 1 advance of medical appointments. The census was 57. The findings were: Confidential interview with 7 residents on 10/4/16 at 1 PM revealed three residents were unhappy with how the facility notified them of their medical appointments. They stated the van driver made their appointments but did not tell them the date and time of the appointments until it was time to leave the facility. They stated they wanted to know, in advance, so they could be "ready to go" and "not surprised." One resident stated s/he communicated the concern to the van driver and he was aware of the problem. Interview with the van driver on 10/5/16 at 2:50 PM confirmed he was responsible for making the medical appointments. He stated he published an updated daily schedule of appointments for the nursing staff and he "tries" to let all the residents know. Further, he stated, "I am not 100% able to say I tell all the residents in advance, but I assume the nurses do." Interview with the DON on 10/5/16 at 4:45 PM revealed residents were not consistently given advance notice of their appointments because some residents would forget and other residents worried about upcoming appointments.	F 154	F154 cont. e) The PIPS leader will be doing an audit to ensure that residents are being notified of upcoming medical appointments. f) The results of the audit will be taken to QAPI on a monthly basis until resolved.	11/18/16
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone	F 164		

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F 164	Continued From page 2 communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interview the facility failed to ensure confidentiality of health information was maintained for 1 resident (#36) and privacy was afforded for 1 resident (#28) of 13 sample residents while receiving care or treatment. The findings were: 1. Observation on 10/4/16 at 9:35 AM showed a medical student entered the room of resident #36 to discuss health concerns. She failed to close the door of the room or pull the privacy curtain before she began her examination. A non-sample resident and the surveyor sat at a table, in the hallway, to the right of the open door. In addition,	F 164	F164 The facility will ensure that confidentiality of health information was maintained for all residents. a) Resident #36 will be spoken to in a private area about his/her health information. b) The med student has been educated on resident privacy: IE visits and communications; resident's privacy will be maintained by a closed door or pulled curtain. Med student verbalized and signed documentation of education. c) All outside contracted staff will be educated and sign facility HIPAA statement to keep resident #36 privacy as well as all residents. d) Resident #28 will be covered after shower while in her room by having curtains pulled and will not be placed where if resident's door opens that he/she could be seen from the hallway. e) Staff in question will be educated on the privacy of all residents including resident #28. f) The PIPS leader or designee will do random audits that ensure residents privacy and confidentiality is being maintained. e) The results of the audit will be taken to QAPI on a monthly basis until resolved.	11/18/16

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F 164	Continued From page 3 LPN #1 stood with the medication cart, in the hallway, to the left of the open door and conversed with activity assistant #1. Conversation between the medical student and the resident regarding the resident's personal health information was heard clearly outside of the room. Interview with the medical student on 10/4/16 at 10:05 AM revealed she did not realize her conversation could be overheard in the hall. Interview with the DON on 10/5/16 at 4:45 PM revealed it was her expectation that all medical information remain confidential. Review of the "Medical Treatment and PRIVACY PRACTICES" section of the admission packet stated: "We are committed to keeping your health information confidential as required by law." 2. Observation on 10/4/16 at 10:48 AM showed resident #28 sitting on a shower chair while being assisted by staff with dressing near the entrance door of his/her room. The resident was exposed and was viewable from the hallway as staff opened the door. Further, the resident was in view of his/her roommate while being dressed as the privacy curtain was not pulled. Interview with DON on 10/5/16 at 5:16 PM revealed staff were expected to provide privacy for residents when performing personal care.	F 164		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248		

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F 248	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide an ongoing program of activities designed to meet individual interests and improve or maintain the physical, mental and psychosocial well-being of residents in 1 of 3 resident areas (secure unit). The census in the secure unit was 19. The findings were: Observation of the secure unit on 10/4/16 from 8:30 AM to 11:40 AM, revealed meaningful, life-enhancing activities were not provided for the residents. During that time, the residents wandered in the halls, slept in their beds, dozed in their wheelchairs, and sat in the dining room. Observation on 10/5/16 at 1:45 PM revealed activity assistant #1 had assisted two residents to the bingo activity off the unit and the remaining 17 residents were not offered activities. Random observations on 10/5/16 showed meaningful, life-enhancing activities were not provided for the residents. Observation of the posted activity calendar on 10/3/16, 10/4/16, and 10/5/16 revealed daily activities for the previous month but none posted for the current month. Interview on 10/6/16 from 7:50 AM to 7:56 AM with CNA #1, #2, and #3, revealed the unit coordinator was responsible for providing activities. The unit coordinator was not on duty that week and they were unsure when she would return to work. They also stated they were unable to provide activities because they were busy providing care for the residents.	F 248	F248 The facility will provide an ongoing program of activities designed to meet individual interests and improve or maintain the physical, mental and psychosocial well-being of our residents. a) All residents in the secure unit will have daily activities that meet individual interests and improve or maintain the physical, mental and/or psychosocial well-being. b) The monthly calendar on the unit will be posted by the first of every month. The calendar will be followed. c) The unit coordinator returned to work on 10/10/16. However in the absence of the unit coordinator the activities director and/or assistant will provide activities on the unit. d) The unit coordinator, Activities Director and activities assistant(s) will be educated on the importance of activities happening on the unit as well as the updated calendar being placed by the first of the month. e) PIPS leader or designee will monitor that the calendar is placed by the first every month and that the activities on the calendar are being followed.	

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F 248	Continued From page 5 Interview with the administrator on 10/5/16 at 3:30 PM revealed the unit coordinator was responsible for the activity program, and no one had been assigned these duties during her absence.	F 248	F248 cont. f) of the audit will be taken to QAPI on a monthly basis until resolved.	11/18/16
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure 3 of 4 resident areas (200 Hall, 300 Hall, Dining Room) were clean and in good repair. The findings were: Observation on 10/5/16 from 2:48 PM through 6:02 PM revealed the following environmental issues: 1. The following issues concerning doors and door frames were identified: a. The inner bathroom door in room #205 had an 8 1/2 inch by 1 1/2 inch chip, which created a surface that could not be cleaned. b. The bathroom door in room #201 had a 6 1/2 inch by 1 inch chip, which created a surface that could not be cleaned. c. The bathroom door in room #302 had a 2 inch chip, which created a surface that could not be cleaned. d. The entrance door to room #301 had a 36 inch chip to the front and back, which created a surface that could not be cleaned. e. The entrance door to room #306 had a 2 inch by 3/4 inch chip, which created a surface	F 253	F253 The facility will ensure that the facility is clean and in good repair. a) The bathroom doors in rooms 205. 201, 302, 306 will be replaced to that ensure that it is a cleanable surface. b) The entrance doors in 301,306 will be replaced to ensure there is a cleanable surface. c) The entrance door into the 300 wing dining room will be repaired to ensure that it is a cleanable surface. d) All tiles in the building that were identified in the 2567 will be replaced to ensure that are a cleanable surface e) The splash guard on the wall in by the bathroom door in room 209 will be replaced to ensure it is a cleanable surface. f) The 300 hall shower room entrance wall that had damage that exposed metal will be repaired to ensure that it is a cleanable surface.	

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F 253	Continued From page 6 that could not be cleaned. f. The bathroom door to room #306 had a 3 inch by 1 1/2 inch chip, which created a surface that could not be cleaned. g. The entrance door to the 300 hall dining room had an 11 inch by 7 inch chip breaking away from the door frame, which created a surface that could not be cleaned. 2. The following issues concerning floors and walls were identified: a. A 12 inch by 12 inch floor tile in the dining room had a 10 inch crack, which created a surface that could not be cleaned. b. The floor near the double doors across from the nurse's station was stained in an area which measured 12 inches by 3 inches. c. A 5 inch by 12 inch floor tile behind the entrance door in room #209 had a 10 inch crack, which created a surface that could not be cleaned. d. A splashguard on the wall by the bathroom door in room #209 had a 4 inch crack, which created a surface that could not be cleaned. e. A 12 inch by 12 inch floor tile in room #201 had a 2 1/2 inch crack, which created a surface that could not be cleaned. f. A 12 inch by 12 inch floor tile behind the toilet in room #202 had a 4 inch and a 5 inch crack, which created a surface that could not be cleaned. g. A 12 inch by 12 inch floor tile behind the bathroom door in room #202 had a 7 inch crack, which created a surface that could not be cleaned. h. Two 12 inch by 12 inch floor tiles at the door to the nurse's desk had multiple pits, which created a surface that could not be cleaned. i. A 12 inch by 12 inch floor tile by the guest	F 253	F253 cont. g) The Maintenance/housekeeping/laundry supervisor and department will be educated on the importance of the facility being clean and in good repair. h) PIPS leader or designee will monitor and audit that all doors, floors, splash guards and walls are in good repair and a cleanable surface. All that are not will be replaced and/or repaired to ensure that they are a cleanable surface. e) Results of the monitoring and audit will be taken to QAPI on a monthly basis until resolved.	11/18/16

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F 253	Continued From page 7 bathroom door had a 3/4 inch chip, which created a surface that could not be cleaned. j. Four 12 inch by 12 inch tiles at the door threshold to room #302 were stained gray. k. A 12 inch by 12 inch floor tile under the toilet in room #306 had a 4 inch crack, which created a surface that could not be cleaned. l. A 12 inch by 12 inch tile in room #308 had a 3 inch crack, which created a surface that could not be cleaned. m. The corner of the 300 hall shower room entrance wall had 13 inch by 5 inch damage which exposed bare metal and created a surface that could not be cleaned. 3. Tour with the maintenance director on 10/6/16 at 8:30 AM confirmed the issues with building damage and cleanliness. At that time he stated he intended to make the necessary repairs; but the facility did not have a plan with a timeframe in place.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)	F 274		

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F 274	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview, and review of the Resident Assessment Instrument (RAI) User's Manual, the facility failed to complete a significant change MDS assessment for 1 of 4 sample residents (#48) who required that assessment. The findings were: 1. Review of the medical record showed resident #48 was admitted to the facility on 6/12/14 with diagnoses which included dementia, stroke and osteoarthritis. Review of the 6/14/16 annual MDS assessment showed the resident required supervision with bed mobility and transfers; and s/he did not have inattention and disorganized thinking. Further review showed the resident was steady at all times during walking, turning, and moving on and off the toilet. The following concerns were identified: a. Review of the 9/14/16 quarterly MDS assessment showed the resident required extensive assistance with bed mobility and transfers, and s/he had disorganized thinking and inattention. Further review showed the resident was not steady with walking, turning, and moving off and on the toilet. b. Interview with the MDS coordinator on 10/6/16 at 9:25 AM revealed a significant change MDS assessment for the resident's decline in status had not been completed. c. Review of the "Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.14" dated October 2016, showed "...A SCSA is appropriate when:...There is a determination that a significant change (either	F 274	F274 The facility will ensure that it completes significant change MDS's for all residents. a) Resident #48 will have a corrected MDS done that is a significant change MDS to correct the quarterly MDS that was done on 9/14/16. b) All residents will have significant change MDS's done in accordance with the LTCF RAI 3.0 User's Manual Version 1.14 dated October 2016. c) MDS nurse will meet with the IDT daily in the am, this will ensure she is aware changes in residents and the IDT will decide if a significant change is needed or not. d) The MDS nurse will be educated on the importance of the accuracy of MDS's. e) PIPS leader or designee will audit that all potential residents who need to have a significant change MDS done is indeed done. f) Results of the audit will be taken to QAPI on a monthly basis until resolved.	11/18/16

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F 274	Continued From page 9 improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident's condition is not expected to return to baseline within two weeks...".	F 274		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278		

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F 278	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the accuracy of MDS assessments for 4 of 13 sample residents (#9, #22, #31, #50). The findings were: 1. Review of the 7/27/16 significant change MDS assessment revealed resident #9 was not at risk for the development of pressure ulcers. However, review of the 7/27/16 Braden scale showed the resident was at risk for pressure ulcer development with a score of 17 (15-18 at risk). During an interview on 10/5/16 at 4 PM the MDS coordinator stated the MDS was inaccurate because the resident was at risk for the development of pressure ulcers. 2. Review of the 3/10/16 admission MDS assessment for resident #22 showed no height recorded. Review of the quarterly MDS assessments dated 6/10/16 and 9/10/16 also showed no height recorded. Interview with the MDS coordinator on 10/5/16 at 3:58 PM revealed CNAs recorded the residents' height on the admission sheet and she did not know why this information had not been included in the MDS data. 3. Review of the July 2016 nurses' progress notes from the medical record of resident #31 showed the resident had falls on 7/10/16 and 7/12/16. However, review of the 7/15/16 quarterly MDS assessment showed only one fall had been documented in section J 1900. Interview on 10/5/16 at 4 PM with the MDS coordinator confirmed the falls were not documented	F 278	F278 The facility will ensure the accuracy of MDS's assessments for all of the residents. a) Resident #9 will have a correct MDS to match the Braden scale that indicated that the resident was at risk for pressure ulcers. b) Resident #22 will have a height measurement done and recorded in his/her assessment. c) Resident #31 will have a corrected MDS done to reflect the two falls that occurred on 7/10/16 and 7/12/16. d) Resident #31 will have his/her Xarelto recorded on a corrected MDS. e) Resident #50 will have a corrected MDS done reflecting whether or not the resident needs a pressure relieving device in his/her WC. f) MDS nurse will be attending nursing briefing with the IDT to ensure that she is receiving communication on residents over all wellbeing which includes but is not limited to falls, height, Braden scale and medications to ensure all of the above are recorded accurately on the MDS. g) The MDS will be educated on the importance of the MDS reflecting the correct assessments.	

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F 278	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, and staff interview, the facility failed to ensure the accuracy of MDS assessments for 4 of 13 sample residents (#9, #22, #31, #50). The findings were: 1. Review of the 7/27/16 significant change MDS assessment revealed resident #9 was not at risk for the development of pressure ulcers. However, review of the 7/27/16 Braden scale showed the resident was at risk for pressure ulcer development with a score of 17 (15-18 at risk). During an interview on 10/5/16 at 4 PM the MDS coordinator stated the MDS was inaccurate because the resident was at risk for the development of pressure ulcers. 2. Review of the 3/10/16 admission MDS assessment for resident #22 showed no height recorded. Review of the quarterly MDS assessments dated 6/10/16 and 9/10/16 also showed no height recorded. Interview with the MDS coordinator on 10/5/16 at 3:58 PM revealed CNAs recorded the residents' height on the admission sheet and she did not know why this information had not been included in the MDS data. 3. Review of the July 2016 nurses' progress notes from the medical record of resident #31 showed the resident had falls on 7/10/16 and 7/12/16. However, review of the 7/15/16 quarterly MDS assessment showed only one fall had been documented in section J 1900. Interview on 10/5/16 at 4 PM with the MDS coordinator confirmed the falls were not documented	F 278	h) PIPS leader or designee will audit MDS's vs actuality of residents needs are being recorded accurately on the residents MDS. i) Results of the audit will be taken to QAPI on a monthly basis until resolved.	~~11/18/16~~ 11/18/16 JC

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F 278	Continued From page 11 accurately. 4. Review of the October 2016 MAR (Medication Administration Record) revealed resident #31 had been prescribed Xarelto (an anticoagulant), 15 milligrams (mg) daily for DVT (deep vein thrombosis) on 1/11/16. Review of the July 2016 medication administration history report showed the resident received the scheduled medication, as ordered, every day in July. However, review of the quarterly MDS assessment dated 7/15/16 revealed the anticoagulant was not included in the medication section of the MDS. Interview on 10/5/16 at 4 PM with the MDS coordinator confirmed the use of the anticoagulant was not documented accurately. 5. Review of the 7/29/16 quarterly MDS assessment for resident #50 showed the resident was at risk for pressure ulcers and a pressure-relieving device was placed in his/her wheelchair. Periodic observations of the resident on 10/4/16, 10/5/16, and 10/6/16 revealed the resident did not have a pressure-relieving device in his/her wheelchair. Interview on 10/5/16 at 4 PM with the MDS coordinator revealed the documentation in MDS was inaccurate because the resident did not need a pressure-relieving device in the wheelchair.	F 278	F282 The facility will provide or arrange a qualified persons in accordance with each resident's written plan of care. a) Resident #28 will be provided eating assistance in accordance to his/her written care plan. Resident #28 has also been given weighted silverware to ensure that he/she has definition of which end of the silverware is to be held on to. Resident #28 also has a scoop plate placed to help him/her define parameters of the plate. He/she has had her care plan updated to reflect the weighted silverware and scoop plate. b) All residents will be provided eating assistance in accordance to his/her written care plan. As well as all care plans will be followed to meet the needs of our residents but not limited to eating assistance. c) Staff will be educated on following the written care plan of resident #28 concerning his/her eating habits and meeting his/her needs and wants. Staff will be educated on the importance of following all residents written care plans. d) PIPS leader or designee will do monitoring on a weekly basis to ensure that #28's nutritional care plan	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	F 282		

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F 282	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to provide eating assistance in accordance to the written plan of care for 1 of 8 sample residents (#28). The findings were: Review of the 7/10/16 annual MDS assessment showed resident #28 required set up help and supervision with eating. Review of the care plan, dated 6/2/16 under the nutritional status category showed "Resident has a poor appetite and will occasionally refuse to eat her meals" and "My staff will queue [cue] me to eat." The following concerns were identified: a. Observation on 10/4/16 from 5:20 PM to 5:54 PM showed resident #28 was at the assistive dining table with a partially eaten meal in front of him/her. During the observation staff did not provide cueing or assistance with eating. b. On 10/5/16 from 12:12 PM and 12:51 PM the resident was observed at the assistive dining table. The resident's meal, which included turkey of mechanical soft consistency, beets, blueberries, a roll, juice and soda, was served at 12:18 PM. The resident attempted to place food on the handle end of the spoon and dropped the spoon on the floor. The resident attempted to feed him/herself with a fork but was only able to get small bits of food after stabbing at it multiple times. At 12:48 PM, a family member entered the dining room and assisted the resident with drinking his/her juice and 2 bites of his/her food. The resident was taken out of the dining room by the family member at 12:51 PM. The resident had consumed a couple bites of the meat and corn side dish, 25 percent of the juice, and all of the soda and beets. During this timeframe the	F 282	f) Results of the monitoring will be taken to QAPI on a monthly basis until resolved.	11/18/16

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F 282	Continued From page 13 resident was approached by the dietary manager who asked him/her if s/he would like something different to eat, but did not offer cueing or assistance. The resident did not receive any cueing or assistance from staff at the table. c. Interview with the MDS Coordinator on 10/5/16 at 3:58 PM revealed the resident needed to be cued and encouraged to eat during mealtime "when [s/he] starts to slow down". d. Interview with the DON on 10/5/16 at 5:16 PM revealed the resident was seated at the assistance table due to his/her need to be cued to eat.	F 282	F283 The facility will provide a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status. a) Resident #58 will have a discharge summary placed in medical record. b) All residents will have a recapitulation of stay done at the time of discharge. c) DON/SS/Medical Records/MDS/Staff Development will be educated on the importance of the recapitulation of stay for all residents and that it has to be done at the time of discharge. d) PIPS leader or designee will audit that a discharge summary/recapitulation of stay is done on all residents discharged from the facility. e) Results of the audit will be taken to QAPI on a monthly basis for three months or until resolved.	11/18/16
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE; RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to complete a discharge summary for 1 of 2 sample closed records (#58). The findings were: Review of the medical record of resident #58 revealed s/he was admitted on 6/15/16 for respite care. The resident was discharged on 8/30/16. No evidence of a discharge summary was in the medical record. Interview on 10/6/16 at 8 AM with	F 283		

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F 283	Continued From page 14 the DON confirmed that a discharge summary was not done. In addition, she stated, "We don't need to do a discharge summary on a respite resident." Interview on 10/6/16 at 8:50 AM with the social services designee revealed: "Respite doesn't have to [have a discharge summary] because they are short term and are private pay."	F 283		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to ensure staff adhered to the sliding scale order for insulin administration for the management of diabetes for 1 of 1 sample residents (#16) with orders for sliding scale insulin. The findings were: 1. Review of the 8/29/16 quarterly MDS assessment and physician progress notes dated 9/13/16 and 9/20/16 revealed resident #16 had type 2 diabetes mellitus. Review of laboratory results dated 7/29/16 showed an elevated A1c (blood test showing average amount of glucose in blood over last 2 to 3 months) at 7.86 percent (normal 4.2 to 6). Review of physician orders showed an order dated 4/28/15 for Humalog KwikPen insulin 100 unit/mL to be given per the	F 309		

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F 309	Continued From page 15 following sliding scale, three times per day: blood sugar (BS) 0-70, give 0 units; BS 71-130, give 2 units; BS 131-180, give 5 units; BS 181-240, give 8 units; BS 241-300, give 10 units; BS 301-350, give 12 units; BS 351-400, give 14 units; and BS greater than 400, give 18 units. The following concerns were identified: a. Review of the September 2016 medication administration record (MAR) showed the insulin was held (not given) on 9/1/16 at 6 AM for a BS of 81, on 9/1/16 at 5 PM for BS of 91, on 9/5/16 at 5 PM for a BS of 102, and on 9/6/16 at 6 AM for BS of 93. According to physician orders, 2 units should have been given on those dates/times per the physician's orders. Review of comments on the MAR showed the insulin was "on hold" and nursing progress notes showed no additional information. During interviews on 10/5/16 at 4:45 PM and 10/6/16 at 8:55 AM the DON stated the resident would sometimes refuse insulin if the BS was below 100; however, the DON acknowledged that the nurse should document resident refusals, and that physician orders should be followed. b. Review of the September and October 2016 MARs showed places for nurses to document the time, the BS results, and the injection site related to the sliding scale insulin; yet lacked a place to document the number of units of insulin administered. Review of the "Reasons/Comments" section of the MAR showed nursing staff occasionally documented the number of units administered. Review of the MAR, including the "Reasons/Comments" section, from 9/1/16 through 10/4/16 showed a lack of documentation of the units of insulin administered 63% of the time (64 of 102 opportunities). During an interview on 10/5/16 at 4:45 PM the DON stated that nurses documented the BS results, and by initialing the MAR, they	F 309	F309 The facility will ensure that staff adheres to the sliding scale order for insulin administration for the management of diabetes for all residents. a) Resident #16 will have her sliding scaled for insulin administered per MD order. b) All residents will have their sliding scale for insulin administered per MD order. c) LPN in question has been educated and counseled regarding following sliding scaled insulin administration per MD orders. d) PIPS leader or designee will audit that resident #16 is having her sliding scaled insulin administration per MD order followed; all residents who are on a sliding scaled insulin administration per MD order will be audited as well. The audit will be done weekly. e) Results of the audit will be taken to QAPI on a monthly basis until resolved. b. All units administered will be documented on the eMAR.	11/18/16

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F 309	Continued From page 16 were basically saying they administered the correct amount of insulin. The DON was unable to provide a current professional standard that showed not documenting the amount of insulin administered was an acceptable practice.	F 309	F312 The facility will ensure that a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. a) Resident #28 will be provided eating assistance in accordance to his/her written care plan. Resident #28 has also been given weighted silverware to ensure that he/she has definition of which end of the silverware is to be held on to. Resident #28 also has a scoop plate placed to help him/her define parameters of the plate. He/she has had her care plan updated to reflect the weighted silverware and scoop plate. b) All residents will be provided eating assistance in accordance to his/her written care plan. As well as all care plans will be followed to meet the needs of our residents but not limited to eating assistance. c) Staff will be educated on following the written care plan of resident #28 concerning his/her eating habits and meeting his/her needs and wants. Staff will be educated on the importance of following all residents written care plans.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review and staff interview, the facility failed to ensure cueing and eating assistance provided for 1 of 8 sample residents (#28) who needed assistance with meals. The findings were: Review of the 7/10/16 annual MDS assessment showed resident #28 required set up help and supervision with eating. Review of the care plan, dated 6/2/16 under the nutritional category status showed "Resident has a poor appetite and will occasionally refuse to eat her meals" and "My staff will queue [cue] me to eat." The following concerns were identified: a. Observation on 10/4/16 from 5:20 PM to 5:54 PM showed resident #28 was at the assistive dining table with a partially eaten meal in front of him/her. During the observation staff did not provide cueing or assistance with eating. b. On 10/5/16 from 12:12 PM and 12:51 PM the resident was observed at the assistive	F 312		

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F 312	Continued From page 17 dining table. The resident's meal, which included turkey of mechanical soft consistency, beets, blueberries, a roll, juice and soda, was served at 12:18 PM. The resident attempted to place food on the handle end of the spoon and dropped the spoon on the floor. The resident attempted to feed him/herself with a fork but was only able to get small bits of food after stabbing at it multiple times. At 12:48 PM, a family member entered the dining room and assisted the resident with drinking his/her juice and 2 bites of his/her food. The resident was taken out of the dining room by the family member at 12:51 PM. The resident had consumed a couple bites of meat and corn dish, 25 percent of the juice, and all of the soda and beets. During this timeframe the resident was approached by the dietary manager who asked him/her if s/he would like something different to eat, but did not offer cueing or assistance. The resident did not receive any cueing or assistance from staff at the table. c. Interview with the MDS Coordinator on 10/5/16 at 3:58 PM revealed the resident needed to be cued and encouraged to eat during mealtime "when s/he starts to slow down". d. Interview with the DON on 10/5/16 at 5:16 PM revealed the resident was seated at the assistance table due to his/her need to be cued to eat.	F 312	d) PIPS leader or designee will do monitoring on a weekly basis to ensure that #28's nutritional care plan is being followed.	11/18/16
F 458 SS=D	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced	F 458		

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F 458	Continued From page 18 by: Based on observation, staff interview, and review of facility records, the facility failed to ensure residents were provided with the minimum of 80 square feet per resident for 3 of 57 residents (#55, #56, #57) residing in the same room. The findings were: 1. Observation during tour on 10/4/16 at 7:30 PM revealed residents #55, #56, and #57 shared the same room. Observation on 10/5/16 at 6:02 PM showed the room measured 190 inches by 126 inches or 166.25 square feet. This provided each of the three residents 55.42 square feet of bedroom space. Interview on 10/6/16 at 9 AM with the MDS coordinator confirmed there were three residents living in the same room. Review of the facility occupancy record showed three residents were assigned to the room.	F 458	F458 The facility will ensure that bedrooms measure at least 80 square feet per resident in multiple resident rooms and at least 100 square feet in single resident rooms. a) Residents #'s 55, 56, and 57 will be placed in rooms that allow 80 square feet per residents. b) All residents be placed in rooms that meet the 80 square feet in semi-private rooms or 100 square feet in single resident rooms square foot regulation. c) The IDT will be educated on the 80 square footage per resident in a semi-private room and 100 square footage per resident in a private room. As well as identifying which rooms are which. d) PIPS leader or designee will monitor to ensure that all residents have the proper square footage. e) The monitoring results will be brought to QAPI on a monthly basis until resolved.	11/18/16
F 465 8S=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure floors were maintained in a sanitary manner in 1 of 1 kitchens. The findings were: 1. Observation of the kitchen on 10/3/16 at 7:01 PM and on 10/6/16 at 8:42 AM revealed the flooring had multiple gaps at seams, which	F 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DOUGLAS CARE CENTER LLC	1109 BIRCH STREET DOUGLAS, WY 82633

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 19 appeared visibly dirty, and created a non-cleansable surface. Specifically, the findings included: a. The flooring at the corner of the walls near the handwashing sink was missing sealant/caulk. b. All four corners at the floor of the doorway entrance to the dish room were missing sealant/caulk. The largest gap created was 6 inches by 1/2 inch. c. On the west wall of the dish room the flooring material was loose at the bottom (baseboard). d. In the kitchen on the east wall, near the plate warmer, there were two cracks in the flooring each measuring 12 inches. e. There was a gap (missing flooring) in front of the north wall of the kitchen, extending the length of the wall from the drain to the left of the walk-in refrigerator and from the right of the refrigerator door to the wall containing shelves. f. There was missing sealant/caulk in the seam extending towards the dry storage room, with the largest measuring 5 inches long. 2. During an interview on 10/6/16 at 8:42 AM, the maintenance supervisor stated he re-sealed the seams, but the sealant/caulk came out. He stated the last time he re-sealed the kitchen floors was about 3 to 4 months previous. He further stated the facility had discussed the flooring in the kitchen, but did not have a plan to repair it.	F 465	F465 The facility will ensure that floors are maintaining in a sanitary manner. a) The kitchen floor will be replaced. The floor will be replaced in sections. b) The Maintenance supervisor, Dietary Manger, Registered Dietician and NHA administrator will be educated on the importance of the kitchen floor and all floors that they are maintained in a sanitary manner. c) The residents will be informed at the next resident council meeting (10/27/16) of the work that is going to be done in the kitchen and that meals will be a continental breakfast, and lunch and dinner will be brought in from an outside entity. Meals will be served on paper plates, with paper cups and plastic silverware. Meals will be served out of the café. d) PIPS leader or designee will monitor to ensure that all the kitchen floor and all floors throughout the building are maintained in a sanitary manner. e) The monitoring results will be brought to QAPI on a monthly basis until resolved.	11/18/16